Great Eastern Life Assurance (M) Bhd v Poobalan a/l Rajah

HIGH COURT (KUALA LUMPUR) — WRIT NO WA-22NCC-475–11 OF 2017
MOHD NAZLAN J
6 DECEMBER 2018

Evidence — Adverse inference — Failure to call witnesses — Failure to call witnesses to establish the defendant's case — Whether failure to call witness justified invocation of s 114(g) of the Evidence Act 1950 — Evidence Act 1950 s 114(g)

Insurance — Claims — Fraudulent claims — Whether defendant made fraudulent claim — Contradictions between defendant's claim and medical evidence — Admissibility of medical information and records

This was an action by the plaintiff that sought to nullify the insurance claims which were said to be fraudulently made by the defendant and for the recovery of the insurance pay-out effected by the plaintiff to the defendant. The plaintiff was an approved insurance company, the defendant was a male individual who bought two insurance policies from the plaintiff. The total premiums payable for the first policy was RM9,895.10 and for the second policy, RM8,447.70 and permanent disability benefits amounting to RM300,000. On or about 19 May 2016, the defendant submitted a claim for critical illness benefits under both policies, by reason of his claim that he had suffered from a stroke with left-sided hemi paresis caused by hypertension. The defendant also furnished the following key documents: (a) the CT scan results performed on 2 May 2016 at Hospital Ampang ('the first scan'); (b) a confidential medical certificate issued by Dr Ami Fairuza Abdul Aziz of Hospital Ampang dated 11 May 2016; and (c) a confidential medical certificate signed off by Dr Izzad Emir Ismail of the same Hospital Ampang. This certificate dated 14 November 2016, confirmed that a result of neurological assessment performed on 10 November 2016, the defendant had been detected to have slurred speech, left-sided muscle wasting with 0–1/5 muscle power on the left upper and lower limbs. The specific diagnosis was identified as cerebrovascular accident (CVA) with left hemi paresis, the prognosis was that it was likely to be permanent. Having evaluated the claims made by the defendant, the plaintiff approved the claim and made payment of a total sum of RM1,013,667.69 direct into the defendant's Public Islamic Bank account on 1 December 2016. The plaintiff got wind of a possible issue on the claim made when the plaintiff was alerted by the Social Security Organisation ('SOCSO') early October 2017 of SOCSO's suspicion that the defendant may have submitted a fraudulent claim to the

plaintiff. The inquires of the plaintiff resulted in the finding of the following facts: (i) the defendant had been issued with a 'Type 2' traffic summons on 12 September 2016 for driving a vehicle with a dirty/faded/fancy number plate which suggested that the defendant was physically able to drive a car on 12 September 2016; (ii) the defendant consulted Dr Streetharan of Klinik Sri Singgam at Sungai Pelek Selangor in December 2016 but never indicated he was a stroke patient neither was there any stroke-related disability observed; (iii) when the defendant was registered as a patient at Hospital Columbia Asia Seremban between 23 January 2017 and 27 July 2017, he neither notified the attending doctor that he was a stroke patient nor exhibited any appearance or gait of one, further, the medical examinations conducted by the doctor too did not produce results which were consistent with a patient who had suffered stroke with left side hemi paresis, as claimed by the defendant; (iv) at the request of SOCSO, Hospital Ampang had also arranged for the defendant to undergo another CT Scan following a doctor's examination on him on 25 September 2017 which concluded that the defendant's neurological findings did not correlate with his alleged condition; and (v) a second CT scan was conducted on the defendant on 27 September 2017 which showed that the area of the infarction (damage) to the brain as a result of the stroke was different from the one exhibited by the first scan. This according to the plaintiff suggested that the first scan and the second scan could not have been done on the same individual. The following were the issues to be tried: (1) whether the defendant had suffered stroke with left side hemi paresis which produced a 'neurological sequelae of a permanent nature' which was the basis of the insurance claim; (2) whether the defendant had furnished a claim for insurance benefits fraudulently or in violation of his contractual promises under the pertinent policies; and (3) whether the defendant had purchased the policies as a scheme to make a fraudulent claim against insurers based on a fictitious medical condition. The arguments of the plaintiff were that: (A) the defendant did not actually suffer the medical condition that he claimed to have suffered from; (B) the defendant submitted a claim based on untrue, false or forged documents with the intention of deceiving the plaintiff into processing and approving the defendant's claim for insurance benefits, the modus operandi of which was that the defendant deliberately arranged for another person as a patient to undergo the computer tomography or CT scan on the defendant's behalf or for the CT scan results to be replaced with another patient's; and (C) the defendant had purchased the insurance policies from the plaintiff as part of a scheme to make fraudulent claims against insurers based on a fictitious medical condition. The defendant contended the following: (I) the defendant denied any wrongdoing on his part and submitted that the plaintiff had failed to prove that it was the defendant who completed or gave data for the issuance of the policy contracts; and (II) the plaintiff had also failed to prove that the defendant did not suffer from stroke on 2 May 2016, the plaintiff's failure to call the medical doctors who treated the defendant and the non-calling of the

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plaintiff's investigation team justify an adverse inference be drawn against the plaintiff's case.

Held, allowing the plaintiff's claim:

(1) The substantial differences in both the first and second CT scans, where the infarcts present in the first scan were not visible or appear in a different location in the second scan clearly therefore showed that the two results must physically and medically be in respect of two different patients. Despite the admission by the defendant that he did undergo three CT scans, the results of these three scans, notwithstanding the records stating them to be in relation to the patient identified as the defendant, would lead to the inescapable and inevitable conclusion, in light of the vastly different findings on the three CT scans, that these three CT scans must in actual fact have been performed on three different patients, and not just one person (see paras 40 & 44).

(2) The version that the defendant gave his appointment card and got someone else to impersonate him in respect of the first and second scan was compelling. The court was satisfied that only the third scan actually examined the defendant as it was done when he was in police custody (see paras 52–53).

(3) The defendant's resistance to the claim by the plaintiff became considerably weakened when evidence of the other physical medical examinations done by a number of doctors on the defendant again did not yield results which were consistent with the kind of stroke as submitted by the defendant to the plaintiff on the basis of the first scan (see para 58).

(4) The defendant himself had signed and furnished four copies of irrevocable letters of authorisation to enable the plaintiff to obtain further information regarding the defendant's health and medical condition. The defendants further authorised any doctor, medical practitioner physician or hospital to supply information to the plaintiff in the very claim form that the defendant submitted to the plaintiff. The doctors themselves gave evidence in court, and the documents were therefore plainly admissible (see paras 66, 68 & 70).

(5) The legal principle of estoppel should rightfully operate to prevent and disapprove of the inequitable conduct of the defendant in attempting to mount such a challenge at this juncture. Even if it the evidence was illegally obtained, which was certainly not the case, such evidence was still admissible if it was relevant to the material facts in issue. The law does not recognise the convenient and self-serving argument that one does not actually understand what one signs (see paras 72–73 & 75).

(6) By reason of the false claims which were made by the defendant intentionally and with deliberate orchestration of a scheme involving other parties who might or might not have themselves been unaware of the fraudulent nature of the same, the defendant had infringed his contractual promise as contained in the relevant policies. The defendant owed a contractual and statutory duty to the plaintiff to make full and frank disclosure of all material facts in the proposal form. The defendant's blatant failure to have made full and frank disclosure of all material facts in the proposal form represented a form of a breach of the policies (see paras 91, 93 & 99).

(7) The defendant chose not to call any witnesses to support his defence. He did not call his sister whom he alleged was the driver of the car who actually committed the type 2 summons offence. Neither did he call the two 'uncles' who accompanied him for the first two scans or any person to offer any testimony about the recovery he allegedly experienced. Further, the failure to call any medical expert to attempt to rebut the overwhelming medical evidence tendered and testified was thus justification for the invocation of the presumption in s 114(g) of the Evidence Act 1950 that the witnesses were not called because their testimony would draw an adverse inference to the defendant's case (see paras 105–107).

[Bahasa Malaysia summary

Ini merupakan tindakan plaintif untuk membatalkan tuntutan insurans yang dikatakan telah dibuat secara penipuan oleh defendan untuk mendapatkan pembayaran insurans dilakukan oleh plaintif kepada defendan. Plaintif merupakan syarikat insurans yang diluluskan, defendan merupakan seorang individu lelaki yang membeli dua polisi insurans daripada plaintif. Jumlah premium yang mesti dibayar kepada plaintif untuk polisi pertama adalah RM9,895.10 dan untuk polisi kedua RM8,447.70 dan faedah kecacatan tetap berjumlah RM300,000. Pada atau lebih kurang 19 Mei 2016, defendan memfailkan tuntutan faedah kesakitan kritikal dibawah kedua-dua polisi, dengan alasan tuntutannya bahawa dia tela mengalami strok dengan 'left-sided hemi paresis' disebabkan oleh hipertensi. Defendan juga mengemukakan dokumen penting berikut: (a) keputusan imbasan CT yang dilakukan pada 2 Mei 2016 di Hospital Ampang bertarikh 11 Mei 2016; (b) sijil perubatan sulit yang dikeluarkan oleh Dr Ami Fairuza Abdul Aziz dari Hospital Ampang bertarikh 11 Mei 2016; (c) satu sijil perubatan sulit yang ditandatangani oleh Dr Izzad Emir Ismail daripada Hospital Ampang juga. Sijil ini bertarikh 14 November 2016, mengesahkan keputusan pemeriksaan neurologi yang dilakukan pada 10 November 2016, defendan dikesan untuk mempunyai pertuturan yang tidak jelas, lumpuh sebelah kiri, tangan dan kaki. Diagnosis yang dikenal pasti adalah *cerebrovascular accident* (CVA) dengan 'left hemi paresis', prognosis adalah bahawa ianya berkebarangkalian tetap. Setelah

meneliti tuntutan yang dibuat oleh defendan, plaintif telah meluluskan tuntutan tersebut dan membuat bayaran berjumlah RM1,013,667.69 ke akaun Public Islamic Bank milik defendan pada 1 Disember 2016. Plaintif mendapati berkebarangkalian, wujud satu isu berkenaan dengan tuntutan yang dibuat apabila plaintif dimaklumkan oleh Pertubuhan Keselamatan Sosial ('PERKESO') awal Oktober 2017 berkenaan dengan kecurigaan PERKESO bahawa defendan mungkin telah membuat satu tuntutan berasaskan penipuan kepada plaintif. Pertanyaan oleh plaintif mengakibatkan dapatan fakta-fakta berikut: (i) defendan telah diberikan saman trafik 'Jenis 2' pada 12 September 2016 kerana memandu kenderaan dengan satu no plat yang kotor/pudar/ragam yang mencadangkan bahawa defendan secara fizikal mampu memandu kenderaan pada 12 September 2016; (ii) defendan merujuk Dr Streetharan dari Klinik Sri Singgam di Sungai Pelek Selangor pada Disember 2016 namun tidak memaklumkan bahawa dia merupakan pesakit strok ataupun diperhatikan apa-apa kecacatan berkaitan dengan strok; (iii) semasa defendan didaftarkan sebagai pesakit di Hospital Colombia Asia Seremban di antara 23 Januari 2017 dan 27 July 2017, dia tidak memaklumkan kepada doktor bahawa dia merupakan pesakit strok mahupun menunjukkan apa-apa rupa ataupun gaya jalan seorang pesakit strok, lanjutan itu, pemeriksaan perubatan yang dijalankan oleh doktor tidak mengemukakan hasil yang konsisten dengan seorang pesakit yang mengalami strok dengan 'left side hemi paresis' seperti mana yang dinyatakan oleh defendan; (iv) atas permohonan PERKESO, Hospital Ampang juga mengaturkan agar defendan untuk melalui satu lagi imbasan CT lanjutan daripada pemeriksaan doktor ke atasnya pada 25 September 2017 yang merumuskan bahawa dapatan neurologi defendan tidak selari dengan keadaan yang kononnya dialami oleh defendan; dan (v) imbasan CT yang kedua dilakukan keatas defendan pada 27 September 2017 menunjukan bahawa kesan penginfarkan sebagai akibat strok adalah berbeza dengan apa yang ditunjukkan oleh imbasan pertama. Ini, berdasarkan plaintif, mencadangkan bahawa imbasan pertama dan kedua tidak boleh dilakukan keatas individu yang sama. Berikut merupakan isu-isu untuk dibicarakan: (1) sama ada defendan mengalami strok dengan left side hemi paresis yang menyebabkan satu 'neurological sequelae of a permanent nature' yang merupakan asas tuntutan insurans; (2) sama ada defendan membuat tuntutan insurans secara penipuan atau pelanggaran ikatan kontraknya dibawah polisi yang berkaitan; dan (3) sama ada defendan telah membeli polisi berkenaan sebagai satu skim untuk membuat tuntutan berasaskan penipuan terhadap membuat tuntutan insurans berdasarkan keadaan perubatan yang direka. Hujahan plaintif adalah bahawa: (A) defendan sebenarnya tidak menghidapi keadaan perubatan yang dikatakan sedang dihidapi; (B) defendan membuat tuntutan berdasarkan dokumen yang tidak benar, direka atau palsu dengan niat untuk menipu plaintif dan menyebabkan plaintif memproses dan meluluskan tuntutan defendan untuk faedah insurans, modus operandinya adalah bahawa defendan dengan sengaja mengaturkan seorang individu lain sebagai seorang pesakit untuk menjalani tomografi komputer atau imbasan CT

bagi pihak defendan atau untuk keputusan imbasan CT diganti dengan satu imbasan milik pesakit lain; dan (C) defendan telah membeli polisi insurans daripada plaintif sebagai sebahagian daripada skim untuk membuat tuntutan berasaskan penipuan berdasarkan keadaan perubatan yang direka. Defendan menegaskan seperti yang beriku: (I) defendan menafikan apa-apa perlakuan salah di pihaknya dan menghujahkan bahawa plaintif gagal untuk membuktikan bahawa defendan yang melengkapkan atau memberi maklumat untuk pengeluaran kontrak polisi; dan (II) plaintif gagal untuk membuktikan bahawa defendan tidak menghidapi strok pada 2 Mei 2016, kegagalan plaintif untuk memanggil doktor perubatan yang merawat defendan dan kegagalan untuk memanggil pasukan siasatan plaintif membolehkan inferens buruk terhadap kes plaintif.

Diputuskan, membenarkan tuntutan plaintif:

(1) Perbezaan substantif diantara imbasan CT pertama dan kedua, yang mana penginfrakan yang wujud dalam imbasan CT pertama tidak kelihatan atau muncul dalam lokasi berbeza dalam imbasan kedua dengan jelas menunjukan bahawa kedua-dua keputusan seharusnya secara perubatan dan fizikal berkaitan dengan dua pesakit yang berbeza. Walaupun defendan mengaku bahawa dia menjalani tiga imbasan CT, keputusan ketiga-tiga imbasan ini, tanpa mengambil kira rekod yang menyatakan pesakit merupakan defendan, akan membawa kepada kesimpulan, mengambil kira perbezaan ketara ketiga-tiga imbasan CT ini, bahawa imbasan CT ini sememangnya dilakukan keatas tiga pesakit berbeza dan bukan seorang sahaja (lihat perenggan 40 & 44).

(2) Versi yang mana defendan memberikan kad temu janjinya dan mendapatkan seorang lagi untuk menyamar sebagai beliau berkenaan dengan imbasan pertama dan kedua menambat perhatian. Mahkamah berpuas hati bahawa hanya imbasan ketiga memeriksa defendan kerana ianya dilakukan sewaktu defendan berada dibawah tahanan polis (lihat perenggan 52–53).

(3) Keengganan defendan terhadap tuntutan plaintif menjadi lemah apabila keterangan semua pemeriksaan perubatan lain yang dilakukan oleh beberapa doktor terhadap defendan tidak mengemukakan dapatan yang konsisten dengan jenis strok yang dikatakan dihidapi oleh defendan kepada plaintif berdasarkan imbasan pertama (lihat perenggan 58).

(4) Defendan sendiri menandatangani dan mengemukakan empat salinan surat berikuasa mutlak untuk membenarkan plaintif mendapatkan maklumat berkenaan dengan keadaan kesihatan dan perubatan defendan. Defendan juga membenarkan apa-apa doktor, pengamal perubatan atau hospital untuk membekalkan maklumat kepada plaintif dalam borang tuntutan yang dihantar defendan kepada plaintif. Doktor berkenaan sendiri telah memberi keterangan dalam mahkamah dan

dokumen-dokumen adalah jelas boleh diterima pakai (lihat perenggan 66, 68 & 70).

(5) Prinsip undang-undang estopel sepatutnya digunakan untuk menghalang dan tidak membenarkan perlakuan tidak saksama defendan dalam cuba untuk mengemukakan cabaran di waktu ini. Jikalau sekalipun keterangan itu didapatkan secara tidak sah disisi undang-undang, yang mana bukan sedemikian didalam kes ini, keterangan sedemikian masih boleh diterima pakai sekiranya ianya relevan kepada fakta material. Undang-undang tidak mengiktiraf hujahan sesuai dan bersifat kendiri yang seorang sebenarnya tidak memahami apa yang dia tanda tangani (lihat perenggan 72–73 & 75).

(6) Atas alasan tuntutan palsu yang dibuat oleh defendan dengan sengaja dan dirancang dengan skim yang melibatkan pihak lain yang akan mungkin atau tidak dengan sendirinya mengetahui kelakuan penipuan yang sama, defendan telah melanggar janji kontraktualnya seperti mana terkandung dalam polisi berkaitan. Defendan mempunyai tanggungjawab kontraktual dan statutori kepada plaintif untuk membuat pengakuan jujur dan ikhlas ke atas semua fakta material dalam borang cadangan. Kegagalan jelas defendan untuk membuat pengakuan jujur dan ikhlas atas semua fakta material dalam borang cadangan merupakan satu bentuk pelanggaran polisi tersebut (lihat perenggan 91, 93 & 99).

(7) Defendan memilih untuk tidak memanggil apa-apa saksi untuk menyokong pembelaannya. Dia tidak memanggil adiknya yang dikatakan merupakan pemandu kenderaan yang melakukan kesalahan saman jenis 2. Dia juga tidak memanggil dua 'pak cik' yang menemani beliau untuk dua imbasan pertama atau apa-apa orang lain untuk memberikan keterangan berkenaan dengan peristiwa yang mana dia kononnya telah sembuh. Lanjutan itu, kegagalan untuk memanggil apa-apa saksi untuk mematahkan keterangan perubatan yang dikemukakan adalah justifikasi untuk mengunapakai anggapan di bawah s 114(g) Akta Keterangan 1950 bahawa saksi tersebut tidak dipanggil kerana keterangan mereka akan membuat inferens buruk terhadap kes defendan (lihat perenggan 105–107).]

Notes

For a case on claims in general, see 8(1) *Mallal's Digest* (5th Ed, 2017 Reissue) paras 45–55.

For cases on failure to call witnesses, see 7(1) *Mallal's Digest* (5th Ed, 2017 Reissue) paras 470–506.

Cases referred to

Fui Lian Credit & Leasing Sdn Bhd v Kim Leong Timber Sdn Bhd & Ors [1991] 2 CLJ Rep 614, HC (refd)

Hap Seng Credit Sdn Bhd v Mohamed bin A Ralim & Ors [2016] 10 MLJ 761, HC (refd)
Juahir bin Sadikon v Perbadanan Kemajuan Ekonomi Negeri Johor [1996] 3 MLJ 627; [1996] 4 CLJ 1, CA (folld)
KGN Jaya Sdn Bhd v Pan Reliance Sdn Bhd [1996] 1 MLJ 233, CA (refd)
Liberty Insurance Bhd v Marrison Anak Sidai & Anor [2018] MLJU 1267; [2018] 6 AMR 893, HC (refd)
Sinnaiyah & Sons Sdn Bhd v Damai Setia Sdn Bhd [2015] 5 MLJ 1, FC (refd)
Wako Merchant Bank (Singapore) Ltd v Lim Lean Heng & Ors [2000] 3 MLJ 401, HC (refd)

Legislation referred to

Evidence Act 1950 ss 73A, 114(g)
Financial Services Act 2013 Schedule 9
Penal Code s 420

Andrew Teh (Sara Anthony with him) (Wong Lu Peen & Tunku Alina) for the plaintiff.
Jason Mathews (Francine Rajendram and IJ Ng with him) (Mathews & Assoc) for the defendant.

Mohd Nazlan J:

INTRODUCTION

[1] This is a writ action for various declaratory reliefs which essentially sought to nullify the insurance claims which were said to have been fraudulently made to the plaintiff by the defendant, and for the recovery of the insurance pay-out effected by the plaintiff to the defendant.

[2] Following the completion of trial, I ruled for the plaintiff and highlighted the key reasons for my decision. This judgment contains the full reasons for my decision.

KEY BACKGROUND FACTS

The policies, the claim and the pay-out

[3] The plaintiff is an approved insurance company. The defendant, a male individual, bought two insurance policies from the plaintiff. The total premiums payable for the first policy was RM9,895.10 and for the second policy, RM8,447.70. Both were for the basic assured sums of RM200,000 each, as well as a rider on, crucially for present purposes, total and permanent disability benefits amounting to RM300,000.

[4] On or about 19 May 2016, the defendant submitted a claim for critical illness benefits under both policies, by reason of his claim that he had suffered from a stroke with left-sided hemi paresis caused by hypertension.

[5] In making the claim to the plaintiff, the defendant also furnished the following key documents. First, and most critically, is the CT scan results performed on 2 May 2016 at Hospital Ampang ('the first scan'). Secondly, a confidential medical certificate issued by Dr Ami Fairuza Abdul Aziz of Hospital Ampang dated 11 May 2016. Subsequently, the defendant handed over to the plaintiff another confidential medical certificate signed off by Dr Izzad Emir Ismail of the same Hospital Ampang.

[6] Significantly, this certificate, dated 14 November 2016 confirmed that as a result of a neurological assessment performed on 10 November 2016, the defendant had been detected to have slurred speech, left-sided muscle wasting with 0–1/5 muscle power on the left upper and lower limbs. The specific diagnosis was identified as cerebrovascular accident (CVA) with left hemi paresis. No less importantly, the prognosis was that it was likely to be permanent.

[7] After having evaluated the claims made by the defendant, the plaintiff approved the claim and make payment of a total sum of RM1,013,667.69 direct into the defendant's Public Islamic Bank account on 1 December 2016.

The suspicion of fraudulent claim

[8] The plaintiff first got wind of a possible issue on the claim made by the defendant when the former was alerted by the Social Security Organisation ('SOCSO') early October 2017 of SOCSO's suspicion that the defendant may have submitted a fraudulent claim to the plaintiff.

[9] Pursuant to inquiries performed by the plaintiff, the following came to light. First, the defendant had been issued with a 'Type 2' traffic summons on 12 September 2016 for driving a vehicle with a dirty/faded/fancy number plate. This suggested that the defendant was physically able to drive a car on 12 September 2016.

[10] Secondly, the plaintiff was informed by one Dr Streetharan of Klinik Sri Singgam at Sungai Pelek Selangor that the defendant had consulted him in December 2016 but never indicated he was a stroke patient. And neither did Dr Streetharan observe any stroke-related disability affecting the defendant.

[11] Similarly, thirdly, when the defendant registered as a patient at Hospital Columbia Asia Seremban between 23 January 2017 and 27 July 2017, he

neither notified the attending doctor that he was a stroke patient nor exhibited any appearance or gait of one. Further, the medical examinations conducted by the doctor too did not produce results which were consistent with a patient who had suffered stroke with left side hemi paresis, as claimed by the defendant.

[12] Fourthly, at the request of SOCSO, Hospital Ampang had also arranged for the defendant to undergo another CT scan following a doctor's examination on him on 25 September 2017 which concluded that the defendant's neurological findings did not correlate with his alleged condition.

[13] This resulted in a second CT scan conducted on the defendant ('the second scan'). This was done at Hospital Ampang on 27 September 2017. Crucially the second scan shows that the area of the infarction (damage) to the brain as a result of the stroke is different from the one exhibited by the first scan. This according to the plaintiff suggested that the first scan and the second scan could not have been done on the same individual.

[14] The plaintiff lodged a police report on the matter on 3 November 2017.

[15] The instant writ action was then filed by the plaintiff on 24 November 2017.

[16] Post the filing of this suit, the defendant was even arrested by the police in relation certain reports and was ordered by the police to undergo a third CT scan. This happened on 13 March 2018, also at Hospital Ampang ('the third scan').

THE RELIEFS PRAYED FOR

[17] The crux of the claim of the plaintiff against the defendant is for a declaration that the claims made by the defendant for the illness he asserted to have suffered from is fraudulent and for the monies paid to the defendant be refunded to the plaintiff.

[18] For completeness and to better appreciate the case of the plaintiff, its claims for reliefs in full, as they appear in the amended pleadings, are as follows:

> 17.1 A declaration that the claim submitted by the Defendant under Policy No. 1016370809 and Policy No. 1019850849 is fraudulent and/or dishonest.
>
> 17.2 A declaration that the claim submitted by the Defendant under Policy No. 1016370809 and Policy No. 1019850849 is in breach of the duties pleaded at paragraphs 7 and 8.

17.3 A declaration that the Defendant holds the sum of RM1,013,667.69 upon a constructive trust for the Plaintiff.

17.4 Further or alternatively, a declaration that the Defendant's said Condition did not continue throughout the Time Period and/or the said Condition ceased to be permanent as pleaded herein, and accordingly the Plaintiff is entitled to the refund of the Policy Monies.

17.5 An order that the Defendant pays the Plaintiff the sum of RM1,013,667.69.

17.6 A declaration that the Plaintiff is entitled to trace the Policy Monies in the hands of the Defendants or elsewhere and thereafter apply to discharge the judgment sum of the Defendant to the Plaintiff.

17.7 An inquiry into what assets of the Defendant, movable or immovable and whether owned legally or beneficially by the Defendant and whether in his own name or not and whether solely or jointly owned, were acquired out of proceeds of the Policy Monies which is held by the Defendant as constructive trustee for the Plaintiff.

17.8 An order that all movable assets held by the Defendant and/or whomsoever consequent upon the inquiry into assets pursuant to paragraph 17.7 herein as constructive trustee be delivered up to the Plaintiff.

17.9 An order that all immovable assets held by the Defendant and/or whomsoever consequent upon the inquiry into assets pursuant to paragraph 17.7 herein so sold by judicial sale by public auction and the proceeds paid to the Plaintiff after deducting all costs and expenses of the auction.

17.10 Interest on all monetary claims above pursuant to Section 11 of the Civil Law Act 1956;

17.11 Interest at the rate of 5% per annum on all the above monetary claims from the date of Judgment until the date of full and final settlement;

17.12 Costs on a solicitor-client indemnity basis; and

17.13 Such further order or other relief as this Honourable Court deems fit and proper.

ISSUES TO BE TRIED

[19] Although the items identified by counsel for parties as constituting issues to be tried are many and various, in essence and substance they may be grouped into only a few real issues to be tried.

[20] First, the overarching issue for determination of this court is whether the defendant had suffered stroke with left side hemi paresis which produced a 'neurological sequelae of a permanent nature'. This was the basis of his insurance claim which was acted on and approved by the plaintiff.

[21] Secondly, in the event it is determined that the defendant had indeed

suffered from the stroke, the case of the plaintiff would come to an end. Conversely if the defendant is ascertained not to have so suffered, the issue would then be whether the defendant had furnished a claim for insurance benefits fraudulently or in violation of his contractual promises under the pertinent policies.

[22] The third issue, which would only be applicable if the second issue is found against the defendant, is whether the defendant had purchased the policies as a scheme to make a fraudulent claim against insurers based on a fictitious medical condition.

SUMMARY OF THE CONTENTIONS OF THE LITIGANTS

[23] The case of the plaintiff is simple and straight forward. It is that the defendant did not actually suffer the medical condition that he claimed to have suffered from. This was the claim for insurance benefits furnished by the defendant.

[24] The defendant, according to the plaintiff, submitted a claim based on untrue, false or forged documents with the intention of deceiving the plaintiff into processing and approving the defendant's claim for insurance benefits. The modus operandi of this deceitful conduct, so the plaintiff claims, is by the defendant having deliberately arranged for another person as a patient to undergo the computer tomography or CT scan on the defendant's behalf or for the CT scan results to be replaced with another patient's. And this was perpetrated not once, but twice.

[25] It is also the key assertion of the plaintiff that the defendant had purchased the insurance policies from the plaintiff as part of a scheme to make fraudulent claims against insurers based on a fictitious medical condition.

[26] The defendant on the other hand, in his opposition to this suit instituted by the plaintiff, denied any wrongdoing on his part and submitted that the plaintiff had failed to prove that it was the defendant who completed or gave data for the issuance of the policy contracts.

[27] Secondly, and more significantly, the defendant also asserted that the plaintiff had also failed to prove that the defendant did not suffer from stroke on 2 May 2016. According to the defendant, the plaintiff's failure to call the medical doctors who treated the defendant and the non-calling of the plaintiff's investigation team justify an adverse inference be drawn against the plaintiff's case.

[28] In essence, the defendant also contended that the plaintiff did not show

A that the defendant had recovered to a condition before the stroke, or that the differences in the three CT scans is attributed to the defendant. Also the defendant made much of the argument that the plaintiff's evidence and its witnesses are tainted with wilful concealment and hearsay evidence.

B THE TRIAL AND THE WITNESSES

[29] At the trial, the plaintiff called fourteen witnesses. They were:

(a) ASP Ahmad Faizal bin Abdul Ghani, a traffic police ('PW1');

C (b) Inspector Norulshuhadad bt Yahaya, a police investigating officer ('PW2');

(c) Thasha Jayamanogaran, a journalist with the *Malay Mail* ('PW3');

(d) Nur Izzati Izzah Nadzi, a journalist with *Utusan Malaysia* ('PW4');

D (e) Choo Wei Yoong, a claims manager with Hong Leong Assurance Bhd ('PW5');

(f) Mashud bin Rusdi, an assistant manager with Public Bank Islamic Bhd ('PW6');

E (g) Chin Jia Gi, an assistant vice president, claims department with the plaintiff company ('PW7');

(h) Murni Wan Omar, a journalist with *Berita Harian*/*New Straits Times Press* ('SP8');

F (i) Nurul Azahar bin Hussien, the Director of Registration Department, Registrar of Societies ('PW9');

(j) Dr Chew Gim Bee, Medical Officer, Columbia Asia Hospital ('PW10');

G (k) Dr Hjh Rosaida bt Hj Mohd Said, Head of Department, Consultant Physician, Gastroenterologist and Hepatologist, Hospital Ampang ('PW11');

(l) Dr Emilianah bt Saidil, radiologist, Hospital Ampang ('PW12');

H (m) Ganaraj a/l Rajaratnam, head of investigations, AIA Bhd ('PW13'); and

(n) Dr Sreetharan a/l Muthusamy, Klinik Sri Singam ('PW14').

[30] The defendant on the other hand chose not to call any witnesses. He gave evidence on his behalf.

I

EVALUATION AND FINDINGS OF THIS COURT

Whether the defendant suffered a stroke

The coverage

[31] The plaintiff's key assertion is that the defendant had submitted false claims under the two policies purchased from the plaintiff. The falsehood concerns the basis of the claim which relates to the medical condition covered under the policies. Specifically, stroke. In other words, the plaintiff is saying that despite the claim by the defendant that he suffered from a stroke which entitled him for insurance payments, the defendant was not actually afflicted by stroke.

[32] In the first place, it is common ground that stroke is an event which is plainly covered by the policies purchased by the defendant. Thus cl 2(2) which appears in both policies defined the 'covered events' as including stroke which is primarily defined (apart from exclusions which are irrelevant for present purposes) as follows:

> A cerebrovascular accident or incident producing a neurological sequelae of a permanent nature, having lasted not less than three (3) months. Infarction of brain tissue, haemorrhage and embolization from an extra-cranial source are included. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a consultant neurologist.

[33] The key question for determination is whether the defendant did suffer stroke with left side hemiparesis (weakness or paralysis), as claimed by the defendant, which produced what was stated in the policies in medical termas 'neurological sequelae of a permanent nature'. Or in other words, stroke which caused some form of permanent disability. The stroke suffered by the defendant must produce nerve damage of a permanent nature.

[34] This was the basis of the insurance claims made by the defendant and paid out by the plaintiff. The defendant had made the insurance claims in question to the plaintiff based on the report of the first scan. And this is the premise of the case of the plaintiff of a fraudulent claim against the defendant.

The differences in the results of the three CT scans

[35] It should be stated that whilst the ailment of a stroke with left side hemi paresis was indeed disclosed in the results of the first scan which had been submitted to the plaintiff, the second scan and the third scan exhibited neurological findings which did not at all correspond with the first scan results.

A **[36]** The undisputed fact is that there are three CT scan reports which are attributed to the defendant as the patient, and all these CT scans were performed at the same hospital. Neither is it denied that the three reports are as a matter of plain fact different from one another. Crucially however, the defendant himself claimed that he had undergone the three CT scans.

B

[37] I find that there is sufficient evidence to support the claim of the plaintiff that the first scan and the second scan are not in respect of the defendant but instead are from different individuals or patients. PW11 in particular testified that the shape of the skull in both these CT scans are
C different. One was rounded, but the other, supposedly of the same patient, was elongated.

[38] Not only that. As testified by PW11, the results of the second scan show
D a severe stroke with an old infarct which is located on the left side of the brain instead of the right. This means, medically and in physical terms, that any changes or weaknesses in the body will be experienced on the reverse side, which should be the right side.

E **[39]** However, the defendant's claim is based on a stroke with left side hemiparesis, pursuant to the findings of the first scan — on which the claims were made to the plaintiff and for which payment was effected to the defendant — which exhibits a stroke on the right side of the brain.

F

[40] The substantial differences in both the first and second CT scans, where the infarcts present in the first scan are not visible or appear in a different location in the second scan clearly therefore shows that the two results must physically and medically be in respect of two different patients.

G

[41] In addition, and more crucially, and as testified by PW11, the third scan confirms that the defendant has a normal healthy brain which does not show the defendant as being a stroke patient. Infarctions cause death or irreversible damage to the relevant tissue.

H

[42] Thus, despite the medical fact that they are permanent and cannot simply disappear, curiously, not only are the specific infarcts present in the first scan do not correlate to the results of the second scan, but that the infarcts in
I the first scan and the second scan too are nowhere to be detected in the third scan.

[43] The third scan shows the neurological findings of a person with a normal brain and who is not a stroke patient.

[44] Thus, despite the admission by the defendant that he did undergo three CT scans, the results of these three scans, notwithstanding the records stating them to be in relation to the patient identified as the defendant, would lead to the inescapable and inevitable conclusion, in light of the vastly different findings on the three CT scans, that these three CT scans must in actual fact have been performed on three different patients, and not just one person.

The process to undergo scanning

[45] In order to appreciate the possibilities involved in the instant case, in particular to answer the question as to how it was possible that the scan results of purportedly the same person demonstrate considerably different neurological findings on the very delicate matters relating to the human skull and the brain, evidence had also been adduced, primarily from PW11 and PW12 as to the process that a patient had to follow in order to have the CT scan performed on him.

[46] It is the clear testimony of PW12 that a patient who has to undergo a CT scan must first have with him a form for such purpose and an appointment card. The patient will secondly have to register with the counter staff in the radiology department and the staff will check the patient's name in the system.

[47] Thirdly, once the name is verified, the patient will be required to wait in the waiting area for his name to be called. Fourthly, the radiographer will when ready call out the patient's name. Fifthly, and this is crucial, the person who responds to the same thus confirming to be the person whose name is called out by the radiographer will be asked to sit on the scan table and the radiographer will key in the patient's name into the scanning system.

[48] This means that there is no additional verification of the identity of the person who comes to the scan table for as long as that person holds the patient card and the form is the named patient.

[49] The case of the plaintiff is that the only explanation for what had happened in the instant case is that another patient underwent the first scan and the second scan pretending to be the defendant. I agree. For a number of reasons.

Evidence of another patient undergoing the first two scans

[50] First, in view of the process (which probably may not be dissimilar to that in other hospitals) it would have been relatively easy for the defendant to register his name at the counter but thereafter arrange for another person to pretend to be the defendant and for this person to present himself at the

A waiting area outside the CT scan room. The person would have been given the form and the appointment card by the defendant and would just need to respond to the name of the defendant being called by the radiographer for the scanning process to be initiated.

B **[51]** Secondly, I cannot but agree with the submission of the plaintiff that based on the evidence given by PW11, it would be impossible for there to be any confusion with the scan digital images by the hospital in view of the fact that the entire process is regulated by the patient's name, appointment card and form. In particular, at the keying in process into the scanning machine, the C patient's name is immediately entered into the system and the images are locked to the patient's name and stored into the system. This leaves the only other plausible explanation. That other persons claimed to be the defendant and underwent the scanning.

D **[52]** Thirdly, the defendant confirmed he was in the hospital on all three occasions and underwent the process himself. And the version that he gave his appointment card and form to someone else to impersonate him in respect of the first scan and the second scan is compelling.

E **[53]** For I am satisfied that it was only the third scan and not the first two which actually examined the defendant. This is given the undisputed fact that the third scan was taken while the defendant was in police custody. His attendance at the hospital for the third scan was accompanied by and under the F custody of police officers.

[54] This was also the testimony of PW12. In other words, he could not, on this specific occasion have orchestrated for another person to pretend to be him in that situation.

G **[55]** In contradistinction, for the first scan and the second scan, the defendant had on the flimsiest of reasons declined to have the scans done immediately but only arranged to have them in subsequent days. This had given the defendant the opportunity to manipulate the process at the hospital H and arrange to have another person to take the place and name of the defendant for the first two scans.

[56] I mentioned flimsy because PW11 testified that when she examined him on 25 September 2017 (due to request which originated from SOCSO) I and suggested he undergo a second scanning and for that purpose get admitted, the defendant refused to have it done the same day, and when later cross examined on this, the defendant offered the explanation that he could not do the same day because his family members were present and that he wanted to send them home first. I cannot but agree with the plaintiff's submission that

this excuse is wholly unconvincing because he was supposed to be the stroke patient who cannot move the left side of his body. And I also agree that he must have wanted more time to arrange for another person to pretend to be him to undergo the second scan.

[57] Indeed, after all, the defendant himself testified that he was accompanied by an 'uncle' for the first scan, and another 'uncle' for the second scan. Yet nobody was called by the defendant to support this testimony.

Examinations on the defendant show his neurological profile could not have been as per the first scan and the second scan

[58] In addition, the defendant's resistance to the claim by the plaintiff becomes considerably weakened when evidence of the other physical medical examinations done by a number of doctors on the defendant again did not yield results which were consistent with the kind of stroke as submitted by the defendant to the plaintiff on the basis of the first scan.

[59] Thus, for one, PW11 gave evidence that when she examined the defendant on 25 September 2017, the defendant claimed he could not move the left side of his body including left hand and left leg. He also said to be suffering from a slurred speech.

[60] However the examination on the defendant as conducted by PW11 produced results which did not support the defendant's complaints. First, the overall condition was found to have been totally inconsistent with that of a patient who genuinely had a serious stroke and having weakness for almost a year. Yet in the instant case, PW11 discovered that there was no muscle wasting and no contracture. Although muscle power was exhibited by the defendant, likely to have been feigned, to be zero, his reflexes and muscle tone are normal.

[61] Secondly, PW11 testified that it was unlikely for the defendant to have suffered from slurred speech because slurred speech would always be attributed to injury to the left side of the brain which also means that any physical weakness would be felt on the right side. As such, since the defendant complained of left side weakness, the injury to the brain must have been on right side.

[62] PW11 also stated that it was unlikely for the defendant to have slurred speech because slurred speech is always due to injury to the left side of the brain which means the weakness if any will be felt on the right side. Since the defendant complained of left side weakness, the defendant could not have

A experienced slurred speech. Moreover, the defendant's admission records in May 2016 did not disclose that the defendant in fact did have any slurred speech.

B **[63]** Further, evidence was also forthcoming from another doctor practising in another medical institution. PW10 testified that only at his third visit on 26 July 2017, did the defendant reveal that he was a stroke patient. This surprised PW10 given the fact that when the defendant consulted him on the two previous occasions, the first on 11 April 2017 and the second on 15 July 2017, the defendant did not exhibit or have any signs or gait of a stroke patient. On top of that, PW10 even performed a physical examination on the defendant which could not be validly said to have found conclusive signs which correlated to the defendant's assertion that he is a stroke patient.

D **[64]** Yet another testimony from a different doctor cast even more serious doubts over the defendant's claim was given by PW14. The defendant consulted with him on 29 December 2016 for fever, and PW14 had no record nor recollection of the defendant being a stroke patient in his clinic.

E Reliance on medical testimony valid

[65] All the CT scans and the doctors' answers to the plaintiff's questionnaire are placed in Part B, and PW11's questionnaire and the attachment thereto which concerned the second scan had been placed in Part C. In view of the testimony of PW11, I had no hesitation in admitting them into evidence.

G **[66]** The defendant's objection to their admissibility on account of the contention that the disclosure of the CT scan results and other medical records were made without the defendant's consent simply does not hold water because not only have these documents all been marked, the defendant himself had signed and furnished four copies of irrevocable letters of authorisation to enable the plaintiff to obtain further information regarding the defendant's health and medical condition. This included attending doctors, medical officers and treating hospitals.

I **[67]** The letter of authorisation and consent to obtain further information for non-death was thumb printed on 10 August 2016 by the defendant as the insured in respect of the policies stated clearly as follows:

LETTER OF AUTHORISATION/CONSENT

To whom it may Concern

Dear Sir/Madam

I, The Life Assured, hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organization, institutions or person that any have any records or knowledge of my/Life Assured's health or medical history ('Information Provider'), to provide such information to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ('the company') and its authorised service provider and/or its employees in order to process my insurance claim.

I, the Life Assured/Assured, expressly waive on behalf or myself or any person who shall any claim or interest in any policy hereunder, all provision of law or professional ethics forbidding any Information Provider from disclosing any Information acquired while attending to me in a professional capacity. This authorisation shall irrevocably bind my successors and assigns and shall remain valid notwithstanding my death or incapacity, and a copy if this form shall be effective and valid as the original.

This authorization/consent is irrevocable and a copy of it will have the same effect and validity as the original.

.....

[68] Similarly the defendant had also authorised any doctor, medical practitioner physician or hospital to supply information to the plaintiff in the very claim form that the defendant submitted to the plaintiff. This of course is standard arrangement to be found in similar insurance coverages.

[69] The authorisation and/consent in the claim form was given by the defendant who signed off on the claims form on 5 May 2016. The pertinent clauses read as follows:

CONFIRMATION ON GST REGISTRATION, DECLARATION & AUTHORISATION BY THE LIFE ASSURED/ASSURED (POLICYOWNER)/CLAIMANT

I, the Life Assured/Assured (Policyowner)/Claimant understand and agree that, GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ('The Company') shall rely on my confirmation in respect of the Policyowner/Policyholder GST registration provided above GST tax credit purposes. I further agree, that in the event any action, claim or proceeding is taken against the Company and/or any fine, charge, penalty or any other GST liability imposed on the Company as a result of relying on my incorrect confirmation on the Policyowner/Policyholder GST registration, I undertake to hold the Company harmless and keep the Company indemnified top the fullest extent permitted by law.

I declare the above answers are true and correct and I agree that if I have made, or shall make any untrue statement, or suppressed or concealed any material fact; my/the Life Assured's right to be compensated shall be absolutely forfeited. I ,the Life assured/Assured (Policyowner)/Claimant hereby authorise and give my consent

> to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organization, institutions or person that any have any records or knowledge of my/Life Assured's health or medical history ('Information Provider'), to provide such information to The Company authorized service provider and/or its employees in order to process my insurance claim. I, the Life Assured/Assured (Policyowner)/Claimant, expressly waive on behalf of myself or any other person who shall have any claim or interest in any policy hereunder, all provision of law or professional ethics forbidding any Information Provider from disclosing any information acquired while attending to me in a professional capacity.
>
> I, the Life Assured/Assured (Policyowner)/Claiman, hereby authorize and give my consent, to the deduction of monies due to the Company from the claim proceeds payable pursuant to any policy hereunder, including but not limited to any Automatic Premium Loan, Cash Loan, overdue interests, premium due, advance benefit paid, erroneous and/or payment made in excess of any claim amount. This authorisation shall irrevocably bind my successors and assignees and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be effective and valid as the original.

[70] In any event, the doctors themselves gave evidence in court. The documents are therefore plainly admissible (see also s 73A of the Evidence Act 1950).

[71] And the defendant does not deny signing these authorisations. He cannot now object to the disclosure of the documents or information obtained by the plaintiff from the doctors, hospitals and other organisations.

[72] In my view, the legal principle of estoppel should rightfully operate to prevent and disapprove of the inequitable conduct of the defendant in attempting to mount such a challenge at this juncture. Reference ought to be made to the decision of the Court of Appeal in *KGN Jaya Sdn Bhd v Pan Reliance Sdn Bhd* [1996] 1 MLJ 233, which held as follows:

> We are of the view that it would be a travesty of justice if we were to accede to the appellant's arguments. We are left in no doubt that the undisputed facts of this case admit of the conclusion that the respondent was, by the conduct of the appellant, lulled into the belief that the appellant had no challenge to the accounts, leave alone the legal relationship between the parties.
>
> To put it another way, the appellant, by its silence coupled with other circumstances of the case, encouraged the respondent to believe that it intended to raise no challenge to the existence of a prior legal relation between the parties or to the figure which the account showed as owing by it. Having do so, it ought not to be permitted to now contend otherwise.
>
> It follows that it does not, therefore, lie in the mouth of the appellant to now deny the respondent's claim. It would be plainly inequitable to do so. An examination of the facts leads us to this conclusion. The legal basis upon which such a conclusion

may be sustained is well-settled and it is now beyond question. See *Boustead Trading [1985] Sdn Bhd v Arab-Malaysian Merchant Bank Berhad* [1995] 3 MLJ 331.

[73] Even if it the evidence was illegally obtained, which is certainly not the case, such evidence is still admissible if is it relevant to the material facts in issue (see *Wako Merchant Bank (Singapore) Ltd v Lim Lean Heng & Ors* [2000] 3 MLJ 401).

[74] The defendant, in an attempt to respond to allegation of false information provided in the application form such as on level of income and existence of policies with other insurance companies also tried to shift the blame to the insurance agent who assisted him purchase the policies. But this attempt to extricate himself from the binding nature of the contractual relationship arising from what had been signed by him is entirely without basis.

[75] In any event, the law does not recognise the convenient and self-serving argument that one does not actually understand what one signs. Certainly not in respect of insurance contracts which demand the utmost good faith as well as full and full disclosure on continuing basis.

[76] The law is settled on the effect of the execution of agreements. Case law authorities are aplenty on this proposition. It binds the parties regardless of whether the parties have read or understood the contents. Thus it is immaterial even if the defendant had not read, let alone understood, any of the terms of any of the documents, in the absence of any allegation of fraud or coercion.

[77] I had the occasion to refer to this principle in the case of *Hap Seng Credit Sdn Bhd v Mohamed bin A Ralim & Ors* [2016] 10 MLJ 761, as follows:

> [46] I should, for completeness, add that the argument that the respondents had not been in the know of the transactions and that the first respondent having merely signed blank forms and did not understand English, and thus ought not to be responsible for the same is not only unsupported with evidence, but also not justified under the law. It is well-established in the law of contract that a person who is a party to a written contract is bound by the terms of the contract whether or not he understands the language in which it is documented, in the absence of fraud or misrepresentation (see *Subramaniam v Retnam* [1966] 1 MLJ 172). No allegation of fraud or misrepresentation had been raised, let alone evidenced in the instant case. In the case of *UMW Industries (1985) Sdn Bhd v Kamaruddin Abdullah & Anor* [1989] 2 CLJ Rep 619, the High Court observed pointedly that:
>
> > As for the second defendant's contention that he only signed blank guarantee forms, he has only himself to blame as the plea of *non est factum* does not work in favour of a person who has shown himself to be negligent.

A The law cannot thus permit the respondents to be excused from the performance of their expressly stated promise as contained in a valid written agreement on the basis of this contention. The following passage from the case of *Imbangan Utama Sdn Bhd v Lotan Engineering Sdn Bhd* [2002] 2 MLJ 313; [2002] 8 CLJ 497 is no less instructive:

B

> It really takes a litigant of unusual temerity or cheerful insouciance to register a plea of non est factum, for such plea rarely if ever succeeds. There is a whole pack of legal cards stacked against such plea. As a defence or a cause of action the onus rests heavily and onerously on the party who alleges non est factum. The signer must establish his lack of competence due to illness or innate incapacity or
>
> C defective education and he was not negligent or had acted nonchalantly or with want of care (see *Saunders v Anglia Building Society* [1971] AC 1004 (HL)). And, he must further establish that he had thought that he was signing a document which was so radically or fundamentally or basically or essentially different in substance or in kind from the document signed (see also *Polygram*
>
> D *Records Sdn Bhd v The Search & Anor* [1994] 3 MLJ 127; [1994] 3 CLJ 806 and *Goh Jong Cheng v MB Melwani Pte Ltd* [1991] 1 MLJ 482; [1990] 1 LNS 160).

[78] Neither could the defendant be entitled to rely on the defence or plea of non est factum because he did not specifically plead such defence. In any event,
E not an iota of evidence was proffered to establish non est factum (see also *Fui Lian Credit & Leasing Sdn Bhd v Kim Leong Timber Sdn Bhd & Ors* [1991] 2 CLJ Rep 614). As such, this argument of the defendant trying to escape responsibility from what he had agreed to is wholly unmeritorious.

F

Other evidence the defendant is not a stroke patient

[79] As if the evidence of the falsity of the insurance claim is insufficient to find liability against the defendant (which is not the case), there are other
G considerations which in my view would overwhelmingly if not conclusively point to the blatant violation of the defendant's duty of good faith under the relevant insurance contracts with the plaintiff.

[80] First is the very appearance of the defendant in court when he attended
H to give evidence for himself. Not unmindful that I am not a medical expert, based on my observation, the defendant's appearance and gait was normal. Just like any other witnesses that have given evidence in this court. Despite the first scan and the second scan, the defendant walked unaided and appeared to have
I no problems at all moving his left limbs.

[81] Secondly, the defendant had also been charged in the Kuala Lumpur Sessions Court under Suit No WA-62K-99–04 of 2018 for cheating under s 420 of the Penal Code based on the police report lodged by PW7.

[82] There are also several criminal charges under the same s 420 of the Penal Code at the Seremban Magistrates Court concerning the complaint lodged by the SOCSO which claimed that the defendant had cheated SOCSO of disability pension by claiming that he was a stroke patient with left sided hemi paresis.

[83] In addition, PW5 also testified that Hong Leong Assurance Bhd had also lodged a complaint against the defendant for cheating of insurance benefits on the same pretext of illness and has also been charged on the same.

[84] Thirdly, PW4, the journalist, had also testified that when she was in court to report on the criminal charges against the defendant at the Kuala Lumpur Sessions Court, she had observed that the defendant's appearance and gait appeared normal to her.

[85] Fourthly, PW7 gave evidence that in her inquiries she had also logged into her Facebook account and was able to access the Facebook pages of the defendant's wife, and a society by the name of *Persatuan Kebajikan Daerah Sepang*, in respect of which the defendant is stated as the chairman of the same. Photographs which were available for public viewing showed the defendant appearing physically normal. These photographs were mostly taken in 2017 which would be after the time he claimed to have suffered a stroke in 2016.

[86] Fifthly, as mentioned earlier in this judgment, a type 2 traffic summons had been issued to the defendant on 12 September 2016 for committing an offence of driving a vehicle with a blurred number plate somewhere along Jalan Simpang Ampat Alor Gajah Melaka. PW1 testified that this meant that the summons defendant's name as owner and the same had been paid by the defendant.

[87] In my judgment, it is clear beyond peradventure that the defendant had in breach of his duty of good faith and other contractual obligations under the policies submitted false claims to obtain insurance benefits from the plaintiff. The defendant's claim that he was a stroke patient is wholly false and deliberately fabricated and contrived.

[88] In his defence, the defendant did contend that he had somewhat recovered as he had done exercise and received traditional medicine treatment. This however is entirely unsubstantiated. In any event it should be emphasised that as testified by PW11, medically it would be impossible for any person to be completely normal again after having a severe stroke with left side hemi paresis and nerve damage of a permanent nature. It was made clear by PW11 that even if one could look normal, and somehow achieved recovery, the patient could still not walk unaided.

[89] Thus PW11 testified as follows as it appears in the notes of proceedings in tab C p 43

Question: Would the patient be able to walk? Unaided?

Answer: It depends, depends how bad even the stroke, if the physiotherapy is good, the patient have is motivated, most of them can actually mobilized but with aid.

Question: With aid.

Answer: Yes.

[90] Evidence that the defendant was not a stroke patient when submission for insurance claims were made by the defendant to the plaintiff has been established. The evidence, as analysed above is both overwhelming and compelling.

Whether the defendant breached the policies

[91] It is clear that by reason of the false claims which were made by the defendant intentionally and with deliberate orchestration of a scheme involving other parties who might or might not have themselves been unaware of the fraudulent nature of the same, the defendant had infringed his contractual promise as contained in the relevant policies.

[92] And it cannot be emphasised enough that it is now settled law as fairly recently affirmed by the Federal Court in the case of *Sinnaiyah & Sons Sdn Bhd v Damai Setia Sdn Bhd* [2015] 5 MLJ 1 that the standard of proof for civil fraud is on a balance of probabilities.

[93] It is only to be expected as it is also contractually stipulated that the defendant owes a contractual and statutory duty to the plaintiff to make full and frank disclosure of all material facts in the proposal form and it is an implied term in the policies that the defendant will not make a claim by fraudulent means and or be in breach of his duty to act in good faith.

[94] In the policies, specifically in cl 7 for instance contains an overriding provision which states as follows:

7. CONDITIONS

This Annexure is valid only if this Policy is valid, and this Annexure is subject to the terms and conditions of this Policy unless stated otherwise in this Annexure.

7.1 General

7.1.1 The due observation and fulfillment of the terms and conditions of this Annexure of this Annexure by the Life Assured and in so far as they relate to anything to be done or complied with by the Life Assured shall be conditions precedent to any liability of the Company.

...

[95] Similarly, in the proposal for assurance which the defendant signed on when agreeing to purchase the policies contain the following binding declaration:

> IX. DECLARATION AD AUTHORISATION BY LIFE TO BE ASSURED AND PROPOSER
>
> I hereby declare and agreed to the following on behalf of myself and any person or entity who may have or claim ant interest in the Policy issued pursuant to this proposal form.
>
> 1. All the foregoing statements and answers in this proposal form together with any other documents or questionnaires submitted in connection with this proposal form and all statement made and answers given to the Company's medical examiners, are complete and accurate ('the information') and I understand that the information given by me is relevant to the Company in deciding whether to accept my proposal or not and the rates and terms to be applied. The company may terminate or void the policy contract (if issued), deny or reduce my claim, or change or vary the terms of the policy contract, if there is any-disclosure, misrepresentation, misstatement, inaccuracy or omission.
> 2. I hereby confirm that save for the relevant sale brochures, sales Illustration and documents duly authorized by the Company, your agent/the FA/the FAR has not given me any document or information to induce me to enter into a contract of assurance with your Company.
> 3. I understand that any change in the state of health and circumstances of the Life to be Assured between the date of this proposal form and completion of this policy contract, must be communicated in writing to the Company.
>
> ...

[96] And that is not all. The parties to an insurance contract like the policies in the instant case are also subject to the provisions of the Financial Services Act 2013, particularly to para 5 of Schedule 9 to that Act which concerns pre-contractual duty of disclosure for insurance contracts. The following passages from my decision in the case of *Liberty Insurance Bhd v Marrison Anak Sidai & Anor* [2018] MLJU 1267; [2018] 6 AMR 893 would suffice to highlight the key obligations that the defendant were subject to and which in the instant case has failed to adhere to:

> [40] Subparagraph (8) reads as follows:
>
> (8) Subject to subparagraphs (1) and (3), a consumer shall take reasonable care to disclose to the licensed insurer any matter, other than that in relation to subparagraph (1) or (3), that he knows to be relevant to the decision of the insurer on whether to accept the risk or not and the rates and terms to be applied.

A [41] Perhaps most significantly, it is in any event made explicit by paragraph 5(9) of Schedule 9 that the duty of the utmost good faith on the part of both the insured and the insurer in respect of the dealings with one another continues unaffected by the provisions of the Schedule. Thus, the First Defendant would continue to be under the duty to make the requisite disclosure in adherence to the duty of utmost B good faith, even after the Policy had been issued. The provision reads as follows:

> (9) Nothing in this Schedule shall affect the duty of utmost good faith to be exercised by a consumer and licensed insurer in their dealings with each other, including the making and paying of a claim, after a contract of insurance has been entered into, varied or renewed.

C

[97] Indeed, separate from the false claims, the defendant had also not disclosed that he had multiple insurance policies with other insurers when he applied to purchase the insurance policies from the plaintiff. In fact, the D income declared was also suspected to be untrue. The defendant had declared in his proposal form that his annual income was RM75,000 for the first policy and RM100,000 for the second policy. On top of that, on both occasions, the defendant represented in the declarations that the defendant had no other existing insurance including those now being proposed to other companies.

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[98] But as testimony of the witnesses were recorded in court, it became manifest that when the proposal forms were submitted to the plaintiff, the defendant was already holding policies from Hong Leong Assurance Bhd and AIA Bhd. A potential insured would be specifically asked in the proposal forms F if he had other existing insurance, but in this case the defendant concealed the truth.

[99] Again this blatant failure to have made full and frank disclosure of all material facts in the proposal form represented a form of a breach of the policies G given the untrue statement when or suppressed or concealed material fact which he should have disclosed to the plaintiff as the insurer.

[100] The income declared in the various policies varies as well despite the H proximity in the dates. And despite the pleading by the plaintiff on the apparent contradictions, the defendant chose not to adduce any evidence of his annual income during the trial, despite his knowledge that the plaintiff has pleaded the inconsistencies in his declared income.

I **[101]** I cannot but agree with the contention of the plaintiff that the proximity in the dates of purchase of the policies and the stroke incident one year later suggest that the defendant did not plan on having a long term commitment. The pattern instead suggests that the purchase of the multiple policies was part of a scheme to defraud various insurance companies.

[102] It is in evidence from the testimony of PW6 and the pertinent documents that the insurance pay-out made by the plaintiff into the Public Islamic Bank account of the defendant amounting to RM1,013,667.69 had been debited and taken out from the account. The defendant's riposte that he had used the cash for treatment and for family expenses is merely a bare assertion without any documentary proof. It is wholly unsubstantiated.

[103] Just like the arguments on his alleged recovery, in respect of his income level as stated in the proposal forms, the defendant has again come short on providing evidential support. This does not help progress the case of the defendant. It has in fact the opposite effect.

[104] In this regard, I should refer to the leading decision of the Court of Appeal in *Juahir bin Sadikon v Perbadanan Kemajuan Ekonomi Negeri Johor* [1996] 3 MLJ 627; [1996] 4 CLJ 1 which reaffirms the rule that 'he who asserts must prove', whereby Siti Norma Yaakob JCA (as she then was) instructively held as follows:

> He who alleges must prove such allegation and the onus is on the appellant to do so. See s 103 of the Act. Thus, it is incumbent upon the appellant to produce Tan Sri Basir as his witness to prove the allegation. The fact that the appellant was unable to secure the attendance of Tan Sri Basir as a witness does not shift the burden to the respondent to produce the witness and testify as to what he had uttered, as firstly, the respondent never raised such an allegation and, secondly, has denied even making one. For this very reason, the adverse inference under section 114(g) of the Act relied upon by the appellant cannot be accepted as establishing that if the witness had been produced, his evidence would work against the respondent. There is no obligation in law for the respondent to produce the witness as that obligation rests with the appellant, the party who alleges, and the fact that the appellant was unable to do so is fatal to his case. For this very reason too, the adverse inference under section 114(g) is invoked against the appellant.

[105] This, the defendant plainly failed to establish. As such, in the absence of evidential support and in the face of the testimony and documents exhibited by the plaintiff referred to earlier that strongly suggest the contrary, the case of the appellant is inevitably one that is considerably lacking in merit, if any. These perfunctory, self-serving contentions are of little help to the defendant. And no less crucially the defendant also chose not to call any witnesses to support his defence. He did not call his sister whom he alleged was the driver of the car who actually committed the type 2 summons offence. Neither did he call the two 'uncles' who accompanied him for the first two scans or any person to offer any testimony about the recovery he allegedly experienced.

[106] Further the defendant also did not call any medical expert to even attempt to rebut the overwhelming medical evidence tendered and testified by

witnesses of the plaintiff, namely the four doctors, PW10, PW12, PW14 and especially PW11. There is thus justification for the invocation of the presumption in s 114(g) of the Evidence Act 1950 that the witnesses were not called because their testimony will draw an adverse inference to the defendant's case.

[107] It must be stressed that if the defence of the defendant is that he is a stroke patient, he must produce evidence to support this stance since the plaintiff in its case had shown to the contrary, more so in a fashion that overwhelmingly calls for an equally strong rebuttal from the defendant. That response never truly came.

Part of a scheme to cheat insurance companies

[108] In respect of the issue of whether the defendant had purchased the policies as a scheme to make a fraudulent claim against insurers based on a fictitious medical condition, as mentioned earlier, there is evidence that SOCSO and other insurers had had to deal with similar claims of doubtful validity, the police reports and investigation as well as the filing of a number of criminal charges against the defendant for cheating.

[109] Also, PW3, a journalist had covered an event where a press conference was called by the then CCID of the Police Director on SOCSO's complaint and the charge against the defendant. The article was written by SP3 based on a press release provided at the press conference which stated that the accused is a chairman of several disabled welfare homes and together with his family members, had filed false claims with SOCSO and four other insurance companies.

[110] All these evidence shows that the defendant had used the same modus operandi to fraudulently claim for insurance benefits from other organisations as well. However other than what has been made available to this court as part of the evidence for case of the plaintiff, it is not in my view necessary to further examine this issue for the instant purpose of determining the civil litigation dispute between two parties.

CONCLUSION

[111] In view of the foregoing reasons and the totality of the evidence I find that the plaintiff has more than successfully established its case against the defendant on a balance of probabilities. I therefore allow the claim of the plaintiff in terms of encl 1.

Plaintiff's claim allowed.

Reported by Izzat Fauzan